STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017437	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT WHITING	**1902 POST ROAD ARNOTT, WI 54481**

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N 000	Initial Comments On 11/24/2025, Surveyor conducted an onsite visit at Wellington Place at Whiting to complete an abbreviated survey and investigate one complaint. Information was received through 12/02/2025. The complaint was substantiated and 4 deficiencies were identified. Census: 23	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not take immediate steps to to	N 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ensure the safety of all residents or promptly begin an investigation after receiving an allegation of abuse.

On 11/18/2025, Resident 1 reported to Caregiver B s/he was sexually abused by a caregiver. Caregiver B immediately informed Administrator A. Administrator A did not begin an investigation until 11/20/2025 and did not take steps to protect residents until 11/21/2025.

Findings include:

The Department received a complaint alleging a resident was sexually assaulted by a caregiver.

On 11/24/2025, Surveyor reviewed hospital records for Resident 1 which indicated s/he arrived on 11/19/2025 at 12:12 PM. The records read in part, "[Resident 1] is an [elderly person] who presented to the emergency department (Ed) with concern of being sexually assaulted." The resident reported discomfort and pain in the perineal region. An exam by the ED physician showed evidence of a tear in the genital area and excoriation (abrasion or wearing away of the skin) which prompted a sexual assault nurse exam and notification to adult protective services. "Patient will be admitted to our facility as [s/he] is clearly unsafe to return to prior facility..." Resident 1 remained hospitalized until 11/22/2025 when [s/he] was discharged to a different assisted living facility.

On 11/24/2025 at 12:00 PM, Surveyor reviewed Resident 1's facility record. S/he was his/her own legal decision maker and did not have diagnoses indicating memory impairment or dementia. The record contained the following progress notes: --11/18 at 1:00 PM: Resident 1 told Caregiver B

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s/he thought s/he "should tell someone what happened to them, but they didn't remember it all. Resident elaborated what they believed had happened to them. Writer assured them that they were right to tell someone and immediately notified administrator.
--11/18 at 10:44 PM: during rounds at 10:30 PM, staff noticed Resident 1's lights were on and Resident 1 explained "[s/he] needed to stay up just in case something happens to [him/her] again, and [s/he] wants the lights on so [s/he] knows what's going on..." Writer was "able to calm resident down...Resident has requested for staff to check on [him/her] more often than normal rounds..."

On 11/24/2025 at 11:02 AM, Surveyor and Detective C interviewed Caregiver B. S/he recalled on Tuesday 11/18/2025, Resident 1 disclosed s/he had been sexually assaulted by a caregiver during the previous week. S/he explained to Caregiver B s/he thought the caregiver gave him/her medication so s/he wouldn't remember the assault. Resident 1 said s/he could not remember the caregiver's name, but provided some descriptors of the accused. Caregiver B said s/he immediately went to Administrator A's office to report the allegations. Caregiver B said Administrator A asked him/her to document the conversation in writing. On Wednesday 11/19/2025 Caregiver B provided the requested, written documentation of Resident 1's disclosure to Administrator A. The same day, Caregiver B observed Resident 1 was crying, was "inconsolable" and making statements like, "why can't they just leave me alone and why can't I remember?" Caregiver B said, "I wasn't in there very long, [s/he] wanted [his/her] phone so [s/he] could call [family]." Caregiver B said Resident 1's baseline was occasional and mild confusion, but

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said s/he had never made an allegation like this in the past.

Surveyor reviewed Caregiver B's written statement on 11/24/2025 at approximately 2:00 PM. Resident 1 gave a description to Caregiver B of the caregiver's gender and hair color.

On 11/24/2025 at 4:13 PM, Surveyor interviewed Caregiver D who was scheduled to work 2nd shift. Surveyor observed s/he matched the gender and hair color of the accused. Caregiver D said s/he had an awareness of the accusations made by Resident 1, but s/he had not yet been interviewed by Administrator A.

On 11/24/2025 at approximately 3:00 PM, Surveyor and Administrator A reviewed the November 2025 scheduled. Caregiver E (2nd shift) and Caregiver F (1st shift) were scheduled each day 11/18 - 11/20. Administrator A stated these 2 caregivers matched the description s/he was provided about the accused caregiver.

Surveyor interviewed Administrator A on 11/24/2025 at 8:27 AM. Administrator A explained on Wednesday 11/19, s/he was informed Resident 1 reported to Caregiver B that s/he had been sexually assaulted by someone at the facility. Administrator A said s/he immediately interviewed Resident 1 but Resident 1 did not make the same disclosure. On that same day, Resident 1's family arranged for Resident 1 to go to the hospital where s/he was admitted and had since moved to a different facility. During a follow up interview with Administrator A at 2:08 PM, s/he said on Thursday 11/20/2025, a detective came to the facility to investigate the allegations and shared information the hospital exam showed evidence of a tear in the genital area. At that

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point, Administrator started an investigation by interviewing staff members and s/he prioritized interviews with those that matched the gender and other descriptors as provided by Resident 1. This included Caregiver E and Caregiver F. Administrator A said s/he had not yet interviewed any residents, but it had been his/her plan for today prior to Surveyor's arrival.

During a follow up interview with Administrator A on 11/25/2025 beginning at 12:20 PM, Administrator A confirmed the following timeline of his/her response:

--Tues 11/18: Resident 1 disclosed an alleged sexual assault to Caregiver B. (Administrator A explained s/he was mistaken when s/he originally told Surveyor this occurred on 11/19.) An investigation was not started.
--Weds 11/19: Administrator A talked to Resident 1, but Resident 1 did not repeat the allegation. Resident 1 was sent to the hospital per family's request. An investigation was not started.
--Thurs 11/20: Administrator A started an investigation consisting of staff interviews.
--11/18 through 11/20: Precautions were not implemented to ensure resident safety.
--Fri 11/21: Administrator A continued with staff interviews. After being prompted by adult protective services, Administrator A implemented a precaution that no caregivers matching the gender of the accused could enter resident rooms of the opposite gender without a 2nd caregiver present.
--Sat 11/22 and Sun 11/23: no investigative steps took place
--As of 11/25: No resident interviews have occurred and Caregiver D had not been interviewed.

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N 158	Continued From page 5 Administrator A acknowledged in hindsight, s/he should have started the investigation and implemented protective measures on 11/18. Administrator A said on 11/18 and 11/19 s/he assumed Resident 1 was experiencing confusion from a recent mini stroke on 11/14/2025 and upon learning of the injuries, thought they may have been due to placement of a urinary catheter on 11/14. Administrator A said s/he wanted to seek additional training in conducting misconduct investigations and would ensure prompt completion of the current investigation.	N 158		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver D, Caregiver E or Caregiver F obtained orientation training before performing job duties. Findings include:	N 230		

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N 230	Continued From page 6 On 11/25/2025 at beginning at 9:30 AM, Surveyor reviewed Caregiver D, Caregiver E and Caregiver F's employee records to verify compliance with orientation training requirements. The record for Caregiver D, hired 12/01/2024, did not contain evidence of orientation training in 5 of 6 required topics. Training was not documented for job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; recognizing and responding to resident changes of condition. The record for Caregiver E, hired 06/12/2025, did not contain evidence of orientation training in 4 of 6 required topics. Training was not documented for job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; recognizing and responding to resident changes of condition. The record for Caregiver F, hired 03/26/2025, did not contain evidence of orientation training in 5 of 6 required topics. Training was not documented for job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; recognizing and responding to resident changes of condition.	N 230		

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N 230	Continued From page 7 On 11/25/2025 at 12:00 PM, Surveyor interviewed Administrator A. S/he confirmed Surveyor's review of the records and agreed there was no documented evidence of orientation training. Administrator A said s/he does not personally provide orientation training, but relies on other lead staff to do it. S/he said in the past there was an orientation checklist but they had gotten out of the habit of using it.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting	N 243		

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N 243	Continued From page 8 employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on source record review and interview, the provider did not ensure Caregiver D and Caregiver E obtained all training as required within 90 days after starting employment. Findings include: On 11/25/2025 at beginning at 9:30 AM, Surveyor conducted a review of Caregiver D and Caregiver E's employee records to verify compliance with all employee training requirements. Additional training documentation was received from Administrator A via email on 12/02/2025. Resident Rights The record for Caregiver D, hired 12/01/2024, did not include evidence of resident rights training within 90 days. Caregiver D did not receive the training until 09/01/2025 as part of continuing	N 243		

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N 243	Continued From page 9 education. The record did not contain evidence of meeting an exemption for training. The record for Caregiver E, hired 06/12/2025, did not contain evidence of resident rights training, or of meeting an exemption for the training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver E did not include evidence of training or evidence of meeting an exemption for training in challenging behaviors within 90 days of hire. Client Group The records Caregiver E did not include evidence of training or evidence of meeting an exemption for training in client group within 90 days of hire. Interview: On 11/25/2025 at 12:00 PM, Surveyor interviewed Administrator A. S/he confirmed Surveyor's review of the records.	N 243		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United	Z 012		

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Z 012	Continued From page 10 States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an out of state background check was completed for Caregiver F. Findings include: On 11/25/2025 at 9:30 AM, Administrator A provided Surveyor with Caregiver F's employee record and said it was complete. Surveyor reviewed the record and noted Caregiver F was hired on 03/26/2025. The record contained a Background Information Disclosure form signed by Caregiver F, dated 03/26/2025. On the form, Caregiver F disclosed s/he resided in the state of Illinois from "09/23/2002 - current." The record did not contain evidence a background check was completed in the state of	Z 012		

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Z 012	Continued From page 11 Illinois. On 11/26/2025 at 9:29 AM, Surveyor sent an email to Administrator A that read in part, "Was an out of state background check completed for [Caregiver F]? [S/he] reported on the Background Information Disclosure Form that [s/he] resided in Illinois in the preceding 3 years. ..." On 11/26/2025 at 3:19 PM, Administrator A replied via email, "I do not have an Illinois background for [Caregiver F]. I will run one from Illinois, but I missed that at new hire and am not in compliance."	Z 012		